Health & Medicine
POLICY RESEARCH GROUP

January 22, 2014

Health and Medicine Policy Research Group submits the following comments in response to Illinois' draft application for a Medicaid 1115 waiver to both the Illinois Governor's Office and Health Management Associates.

- As DSH payments decline, safety net hospitals will continue to care for the over half-million people who will remain uninsured and will likely be disproportionately medically and psychologically complex. Waiver funds should be dedicated to care for this population to ensure access to care and improved population health.
- The universal assessment process must be transparent and guided by stakeholder involvement. It is important to assure that consumers will not face cuts, waitlists, or interference with consumer direction. The service benefits under the 1115 waiver should at least match the old service package minimums. The waiver should adopt the definitions and standards from the CMS final regulations for the HCBS[1]. We support use of the Community First Choice Option in conjunction with the 1115 waiver to expand and improve access to and funding of HCBS.
- Develop advisory boards that include patients/clients for new integrated delivery systems. Require that providers/health systems engage in meaningful ways with advisory boards.
- Ensure that quality within integrated delivery systems is measured and meets National Quality Forum Standards.
- Ensure that Medicaid enrollment and access to services are seamless for youth who have been incarcerated. Pay special attention to the need for exchange of health records and care coordination as youth leave jails and prisons.
- Some people in nursing homes are able to return to their communities but only if their cases are mandatorily reviewed and they are able to maintain income adequate to pay rent and return to their homes. Sixty day review of all patients should be mandatory and residents should be allowed to keep all of their SSI payments.
- A barrier to effective de-institutionalization has been the dearth of affordable and accessible housing in the community with services. Most successful de-institutionalizations have been to operate Supportive Living Facilities. There are currently 8000 units of Supportive Living statewide, with 3000 units under development. New production under this program has been discontinued; however, the State can seek to replicate the success of its CCRS program by crafting a new program, utilizing Medicaid to pay for assisted living services within the State's existing affordable housing. The model is Luther Towers in Rockford, where two floors were converted to assisted living with service costs paid by the State. Although the new production of affordable housing has steadily

[1] Federal Register January 16, 2014, Vol. 79, No. 11 at 42 CFR 430, 431 et al

declined due to diminished or terminated capital programs, Illinois has a large stock of existing housing that was originally designed for independent living. See HMPRG's previous comments for more examples and details.

- As Texas did in their 1115 Waiver, dedicate a 5% set aside of waiver funds for public health efforts. Investment in population health and prevention will result in long term health improvement and cost savings. This funding should go to increase local health protection grants, to local health departments, the state public health department, and some for non-governmental units that provide prevention and public health services.
- Request matching dollars for some health department activities such as vaccinations and safe sex/sex education programming by asking for specific activities that promote population health to be considered as costs not otherwise matchable.
- In many parts of rural Illinois public hospitals are struggling and their financial challenges are likely to intensify over the next couple of years. Consider including a provision in the waiver for delivery system reform incentive payments (DSRIP) for rural hospitals. Critical access hospitals likewise need support to guarantee healthcare access.
- Develop mechanisms to monitor roles and responsibilities of members of integrated care teams. Quality standards should incentive the use of clinically appropriate staff, which may not always be the least expensive staff, while reimbursement and scope of practice rules should allow all trained staff to work to the top of their license (but no higher).
- The 21st Century Healthcare Workforce Pathway should reflect the draft waiver application's stated commitment to addressing the social determinants of health, guided by stakeholder involvement.
    - Incorporate requirements for living wages, quality health insurance, and paid sick leave into all workforce development initiatives
    - Support development of certification programs for direct care workers as well as CHWs
    - Include non-physician providers in loan repayment programs
- HMPRG supports the integration of Community Health workers into coordinated care teams and broader integrated delivery systems. It is necessary to develop a reimbursement system for CHW services as part of care teams and that reimbursements provide CHWs with a living wage.
- Enhance reimbursement to PCPs for expanded care and providing more comprehensive services such as

Primary Care Medical Home models. Also, incentivize health centers to integrate behavioral and physical health.

- HMPRG is very pleased that the draft of the waiver has such a great emphasis on the importance of the social determinants of health (SDH). For clarity, the application should define the social determinants of health using the World Health Organization's definition.

- While we are happy that there are efforts to address the SDH, the waiver application should strengthen its approach by including direct poverty-reducing initiatives within the health care delivery system.[2] Below are several ways that the waiver can address poverty:

- Define what is meant by a "living wage" on page 23 of the draft waiver application and apply this as a standard throughout the waiver implementation. Require as a performance metric whether or not providers and plans offer a living wage, health insurance, and paid sick leave to all employees and contractors,
    - Using the living wage, health insurance, and paid sick leave for all workers standard, as a performance metric for hospitals and health systems participating in the Health System Integration and Transformation Performance Program and for HCBS providers participating in outcome-based reimbursement strategies.
    - Using the living wage, health insurance, and paid sick leave for all workers standard in all Medicaid managed care contracts.

- Guaranteeing sick leave is also a way to help reduce the spread of illnesses and to reduce unnecessary emergency department usage by allowing people who are sick or who have a child who is sick to visit primary care providers during regular business hours, instead of using an ED when they happen to be able to leave from work.

- For hospitals and health systems participating in the Health System Integration and Transformation Performance Program, provide a metric for hospitals to embrace their mission as anchor institutions. As examples:

- Hospitals might provide housing by setting up community land trusts that expand affordable housing.
- Hospitals can focus on increasing purchase of goods and services from local businesses, as well as from minority- and women-owned businesses.

[2] See http://www.who.int/topics/poverty/en/, , "..the evidence shows that in general the lower an individual's socioeconomic position, the worse their health."

- We are pleased to see the proposal to continue funding for HRSA's Graduate Medical Education Teaching Health Centers program. HMPRG supports continuation of the teaching health center model and that it be structured similarly to the federal Teaching Health Center Program to either replace or expand this program. We recommend the use of federal guidelines for funding, so that dollars flow directly to a community health center or to a consortium with a CHC as the primary training location.

- The proposal to create a registry for justice-involved patients (page 15 of the waiver draft) raises serious concerns about privacy and stigmatization related to people who have a background with the criminal justice system. Any effort to improve services and care coordination for people who are justice-involved must ensure patients' privacy, dignity, and equitable treatment. Advocates who have experience with this population need to be heavily involved in developing this initiative.

- The Access Assurance Pool seems to place existing UPL payments in the waiver without truly expanding access to care beyond the degree to which the current scope of this program does so. Yet it also insulates UPL payments from the impact of managed care expansion, a significant benefit to Illinois' hospitals. Many Illinois non-profit hospitals currently provide levels of charity care that are less than the value of their tax exemptions. Concurrently, for-profit hospitals have expanded their presence in Illinois, and there are limited policy levers to require those hospitals to provide care to people who are unable to pay their bills or insurance cost-sharing. To help address that situation and provide for the need for healthcare of un- and under-insured people, the waiver should require provision of a minimum level of charity care—defined as free or discounted care, valued at cost—as a prerequisite for participating in the Access Assurance Pool. This will provide for greater accountability of nonprofit hospitals for their tax exemptions and integration of for-profit hospitals into a safety net system, while providing care to some of the State's most vulnerable residents. This represents a win-win-win scenario for the State and hospitals to preserve this important source of revenue, while more equitably meeting the health needs of Illinois residents.

- We oppose any waiver of the IMD exclusion for Specialized Mental Health Rehabilitation Facilities (SMHRFs) as contradictory to the rebalancing goals of the waiver.

- The draft waiver application is too heavily invested in a medical model and lacks a clear recognition of the impact of its proposals on people with disabilities. In particular, the description of HCBS expansion as focusing on 'those with complex health and behavioral health needs,' raises concerns about how changes to HCBS that will affect

people with disabilities will align with the needs, preferences, and values of people with disabilities themselves.

- The changes in waiver services and other reforms in the waiver application imply significant changes to state agency responsibilities and relationships. Articulate what those changes are likely to look like in a timely, transparent, and collaborative manner.

- The draft waiver outlines Regional Public Health Hubs, starting on page 21, proposing a "premium add-on payment for health plans that agree to use the funds to develop population health interventions in conjunction with the Regional Health Hubs". We have concern that this may move control and leadership for community health planning and program development away from local health departments -- who have decades of experience and expertise with such activities -- and toward the Regional Hubs. The premium add-on payment funds should be provided to State and local health departments to bolster their efforts for prevention, wellness, and other public health activities.

- As Illinois moves toward an integrated delivery system, it should reimburse providers for use of the Adverse Childhood Experience Questionnaire Assessment. Reimbursements should be for both the assessment and followup. Also, providing assessment and followup through this assessment could be part of scoring for Managed Care Organizations.

- The Medicaid GME proposal in the draft waiver application includes a set-aside for population medicine-based curricula. We recommend that the "appropriate management of patient transitions of care" competency include training based on the Bridge Model, an evidence-based, person-centered, social work-driven, interdisciplinary model of transitional care that works collaboratively with health systems and community-based organizations. See transitionalcare.org or contact HMPRG for more information.

- Recognizing that not all the programs in the waiver will reach all populations and all geographies simultaneously, one role of the Integration and Transformation Resource Center should be to coordinate 'scaling-up' and replication of projects, paying special attention to appropriate implementation in rural areas.

Respectfully submitted,

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